

PHYSICAL DISABILITIES CRITICAL NEEDS ASSESSMENT

check one: Initial Assessment [] Petitioned Assessment []

Person's Name: _____

Date: _____

ID Number: _____

Worker: _____

Does this person have the cognitive ability to self-direct a personal assistant? ☐ yes ☐ no

Desired / Needed Services:

Attendant _____
Personal Response System _____
Consumer Preparation _____
Liaison Services _____

Supports Currently Received:

Home Health/CNA: _____
Medication Management: _____
Residential: _____
Other: _____

Diagnosed Conditions:

(check all that apply)

☐ Physical Disability
Cause _____
Date of Onset _____
☐ Paraplegia
☐ Cerebral Palsy
☐ MS
☐ Neurological
☐ Mental Illness
☐ Deafness
☐ Blind
☐ Other

_____ 1. Support System: (Score range 0 to 7)

Describe the composition of natural supports provided by family and friends. Does the person live with parents? Are the person's parents elderly? Do other individuals with special needs live at home? How is the health of the primary care giver? Does the person receive SSI, Medicaid, Housing Assistance? Does the person enjoy financial stability, hold a job, etc?

_____ 2. Special Medical Needs: (0 to 10 points)

Assess the person's physical health, are there problems? What special adaptive equipment is necessary for the person?

_____ 3. Protective Service Issues: (0 to 9 points)

List issues facing the person (homelessness, abuse, neglect, exploitation, financial exploitation, etc.).

_____ 4. Projected Deterioration Issues: (0 to 9 points)

What will happen if the service is not provided immediately? (divorce, deterioration of family, death of care giver, etc.).

_____ 5. Resources/Supports Needed: (0 to 10 points)

Considering all supports/resources currently available to the person (e.g., other agencies, church, friends, community, family, school, etc.) what further supports does the person need?

PERSONAL ASSISTANCE CRITICAL NEEDS ASSESSMENT**6. Functional Status:** (0 to 54 points)

Rate each functional activity listed below using the rating scale on the right, then determine the approximate hours of personal support per week the person will need using the total score and the Personal Assistance Hours Needed chart.

FUNCTIONAL STATUS/ACTIVITY	RATING			
1. In/out of bed	0	1	2	3
2. In/out of chair	0	1	2	3
3. Toileting	0	1	2	3
4. Bathe	0	1	2	3
5. Groom	0	1	2	3
6. Dress/undress	0	1	2	3
7. Drink/eat	0	1	2	3
8. Take medication	0	1	2	3
9. Mobility in home	0	1	2	3
10. Use telephone	0	1	2	3
11. Prepare meals	0	1	2	3
12. Dishes	0	1	2	3
13. Clean House	0	1	2	3
14. Laundry	0	1	2	3
15. Admit visitors	0	1	2	3
16. Manage finances/mail	0	1	2	3
17. Socialize	0	1	2	3
18. Communicate	0	1	2	3
TOTAL SCORE _____				

RATING

0 = Independent with or without mechanical devices

1 = Minimal assistance

2 = Moderate assistance

3 = Cannot accomplish

Estimated Weekly Personal Assistance Hours

_____ Hours per Week

PERSONAL ASSISTANT HOURS NEEDED		
Hours/Week	Total Score	Level of Need
36 or more	40 - 54	Intense assistance
28 to 35	25 - 39	Moderate assistance
14 to 27	18 - 24	Minimal assistance

7. Time on Waiting List: (0 to 10 points)

Total the length of time the person has been on the waiting list from the date the application was received (1 point for every ½ year, up to 10 points maximum).

TOTAL SCORE (100 points possible)_____
Nurse Coordinator